

**CORRECTED COPY**



**State of New Jersey**  
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS  
POST OFFICE BOX 340  
TRENTON, NEW JERSEY 08625-0340

JON S. CORZINE  
*Governor*  
*Commander-in-Chief*

☆☆  
GLENN K. RIETH  
*Major General*  
*The Adjutant General*

**VETERANS AFFAIRS BULLETIN**

**19 June 2006**


**No. 2-06-Corrected**

**REQUIRED RECURRING REPORTS**  
**NEW JERSEY VETERANS MEMORIAL HOMES**

1. Remove and destroy *Attachment 6, Page 1 of 1 and Attachment 7, Page 1 of 3 thru Page 3 of 3* from the *original issue* of Veterans Affairs Bulletin No. 2-06, 19 June 2006. Replace with the enclosed Attachment 6, pages 1 thru 4.
2. Questions or inquiries concerning this bulletin should be addressed to BG Frank R. Carlini, Director, Division of Veterans Healthcare Services at 609-530-6766 or e-mail [Frank.Carlini@njdmava.state.nj.us](mailto:Frank.Carlini@njdmava.state.nj.us).

OFFICIAL:

GLENN K. RIETH  
Major General, NJARNG  
The Adjutant General

  
DAVID S. SNEDEKER  
Chief Information Officer  
Acting Director, Information and  
Administrative Services Division

Corrected Attachments

DISTRIBUTION: A, S (New Jersey Veterans Memorial Homes)

**REPORTABLE EVENT RECORD/REPORT**

**New Jersey Department of Health and Senior Services  
Division of Long Term Care Systems  
Assessment and Survey Program/Complaint Unit  
P.O. Box 367  
Trenton, NJ 08625-0367**

**Hotline: 1-800-792-9770, Select 1  
Off Hour Emergencies: 609-392-2020**

The following is a list of reportable events that **must** be called in to the Department of Health and Senior Services at 1-800-792-9770 or in the off hours to the state operator at 609-392-2020.

- A suspicious and/or unexplained death/murder
- An allegation of rape or substantiated sexual assaults
- Any event that would cause significant damages to the facility structure such as a major fire or structural collapse of area-affecting residents
- Significant unexplained injuries, such as head injuries, multiple fractures
- An impending job action, strike action, or staff walk out
- The evacuation of residents from a facility
- Temporary loss of a major system (electric, water, heating, air conditioning) for more than three (3) hours
- Temporary loss of a major system that cannot be repaired within 24 hours
- Egregious allegations of abuse/neglect and substantiated abuse cases, which result in significant injuries
- Significant infectious outbreaks
- Missing residents

This is not an all-inclusive list; there may be other egregious events that occur that you must also report.

**New Jersey Department of Health and Senior Services  
Division of Long Term Care Systems  
Assessment and Survey Program / Complaint Unit  
P. O. Box 367  
Trenton, NJ 08625-0367**

**Hotline: 1-800-792-9770, Select #1  
Off Hour Emergencies: 609-392-2020  
Fax: 609-943-4977 or 609-633-9060**

**REPORTABLE EVENT RECORD/REPORT**

*Please answer all questions fully and address only one event per report.*

Today's Date (MM/DD/YY)	Date of Event (MM/DD/YY)	Time of Event
<input type="text"/>	<input type="text"/>	<input type="text"/> AM <input type="text"/> PM

Was This a Significant Event?	Was Significant Event Called In?	Date (MM/DD/YY)	Time
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/> AM <input type="text"/> PM

Full Name of Facility
<input type="text"/>

Street Address
<input type="text"/>

City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Facility Telephone Number	Facility License Number	Provider ID Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Person Reporting	Title
<input type="text"/>	<input type="text"/>

**Type of Facility:**

- ☐ Assisted Living or Comprehensive Personal Care Home  
☐ Adult/Pediatric Day Health Services  
☐ ICF/MR  
☐ Nursing Home  
☐ Residential  
☐ Sub-Acute Care  
☐ Other, Specify:

<input type="text"/>
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**Exact Location of Incident:**

<input type="text"/>
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**Type of Incident:**

- |  |   |
|--|---|
| <input type="checkbox"/> Elopement               | <input type="checkbox"/> Involuntary Relocation     |
| <input type="checkbox"/> Environmental Emergency | <input type="checkbox"/> Medication Error           |
| <input type="checkbox"/> Financial Exploitation  | <input type="checkbox"/> Resident Care              |
| <input type="checkbox"/> Injury                  | <input type="checkbox"/> Resident-to-Resident Abuse |
| <input type="checkbox"/> Interruption of Service | <input type="checkbox"/> Staff-to-Resident Abuse    |
| <input type="checkbox"/> Involuntary Discharge   | <input type="checkbox"/> Unexpected Death           |

☐ Other, Specify:

Resident Name

Unit and Room Number

Date of Birth

**Narrative:**

1) Describe the event, to include timeframes/risk factors related to the incident/event (relevant resident Dx):

2) Prior to the event, was a plan of care developed that addressed this issue, and were planned interventions in place when the event occurred? For example, chair alarm and/or lap buddy in place.

☐ Yes      ☐ No      If Yes, please describe:

3) What interventions were implemented after the incident/event? For example, supervision, resident sent to hospital, CNA suspended. Please describe investigative findings/conclusions:

**Nurse Aide Involvement:**

If the event is an allegation of abuse, neglect, or misappropriation of resident funds by a nurse aide, please provide the certification number and certificate expiration date. For a nurse aide with no certification, please provide the Social Security Number.

Name	Certification Number	Expiration Date

**Notifications:**

☐ MD, Specify:

☐ OOIE (Ombudsman), Specify Date:  Time:  ☐ AM ☐ PM

☐ Other, Specify:

**FOR NJDHSS USE ONLY****Reviewed By:** (Surveyor ID Number and Initials)

Date (MM/DD/YY)

**Other Review:** (ID Number and Initials)

Date (MM/DD/YY)

**Disposition:**

- ☐ Pending
- ☐ No Action
- ☐ Complaint Investigation

☐ Referral, Specify:

☐ Closed, Specify Date Closed:

**Comments:**